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THE ROLE OF TREATMENT AND PREVENTION IN THE NATIONAL DRUG STRATEGY

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

EXAMINING THE ROLE OF TREATMENT AND PREVENTION IN THE NATIONAL DRUG STRATEGY

APRIL 24, 1990

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THE ROLE OF TREATMENT AND PREVENTION IN THE NATIONAL DRUG STRATEGY

TUESDAY, APRIL 24, 1990

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee), presiding.

Present: Senators Kennedy, Simon, Harkin, Adams, Hatch, Kassebaum, Coats, Thurmond, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

Today we welcome Dr. William Bennett to the Committee on Labor and Human Resources. This is Dr. Bennett's first appearance before the committee in his role as director of National Drug Control Policy.

The Labor and Human Resources Committee has jurisdiction over two key aspects of the anti-drug strategy—treatment and education. These programs, the "demand side" of the effort to combat drug abuse, must play a central role in our national drug strategy. Law enforcement and interdiction cannot do the job alone.

Real gains against the stranglehold of addictive drugs will be made when students are persuaded that drug use is harmful, when communities rally together to create a climate in which drug use is unacceptable and when treatment is offered to all who wish to rid themselves of a drug habit.

Unfortunately, neither the Reagan Administration nor the Bush Administration has given drug treatment and prevention the attention and emphasis they deserve. Their war on drugs places undue reliance on law enforcement to address the tangle of social factors that contribute to the self-destructive behavior of drug use. Simply put, the current national strategy lacks balance.

Last year the administration sent a proposal to Congress to allocate 70 percent of the anti-drug budget to law enforcement and interdiction. The Democratic leadership in Congress added an additional $800 million for treatment and prevention. This year, the administration has again proposed an equally lopsided allocation of resources: 70 percent to reduce the supply of drugs and 30 percent to reduce demand. Once again Congress must redress the imbalance and restore common sense to the drug strategy.

Dr. Bennett's own action and words reflect this bias against treatment and education. He has used his office as a bully pulpit, but he has largely preached the gospel of law enforcement. Throughout his tenure, he has refused to endorse the fundamental goal of treatment on request for every addict who seeks it. Then, at a recent Judiciary Committee hearing, he belittled the importance of drug education.

Drug use is a crime, but it is also a disease, and we can treat it with a fairly high degree of success. Treatment works. It reduces drug abuse, increases employment, decreases crime and decreases the need for emergency medical intervention. One major study found abstinence rates of 40 to 50 percent and improvement rates of 70 to 80 percent in the 3 to 5 years after treatment. According to another study, every dollar spent on drug treatment saves over $11 in future costs to society.

Drug education works, too, especially when reinforced by a comprehensive, community-based prevention effort. When used in the early grades of school, it leads to dramatic reductions in the use of gateway drugs and cocaine in later grades.

These charts over here are particularly instructive. These are basically NIDA charts; I am sure the director is familiar with them. They are based on 17,000 students, seniors in high schools, from 1975 through 1989. The top blue line is the availability of marijuana; the green line represents the use, and the red line indicates the risk.

So what we are finding out from this NIDA study over the period from 1975 to 1989 is that either the perception or reality in terms of high school seniors as to availability of marijuana remained fairly constant during this period of time. As there is increasing understanding of risk, there is a corresponding diminution in terms of use. That is certainly something, in a battle of this dimension, that ought to offer some degree of hope in terms of behavioral changes. I think we have seen important behavioral changes, for example, in smoking over the period of years that—with the exception of young women, teenage women, and certain small targeted groups and minorities—there has been a significant decline, and we are also seeing that with the consumption of alcohol. So that offers some degree of hope.

The other chart indicates a similar kind of result on the issue of cocaine in high schools. From 1975 through 1989, there has actually been some increase at least in terms of the understanding of young people availability over that period of time, and I think that is generally something which most would agree in terms of other kinds of studies outside of NIDA. The risk is demonstrated by the orange line, where the perception of risk has gone up, and we see rather significant, dramatic reductions in terms of use of cocaine in high schools.

I think that date pretty well corresponds to the death of Len Bias, the rather extraordinary athlete who had a very tragic death.

So there has been a lot of effort in schools. We will have a chance to talk with the director about what programs work and what don't, and hopefully we'll agree that the programs of education that have not got the strong community base, support within the business community, religious groups and families are not ter-

ribly meaningful, but other programs which incorporate those elements—there are a variety of different reviews that have been done on that in Seattle, Kansas City, and most recently the Rand studies sponsored by the Hilton Foundation. I think Rand deserves credit for both the study and the way Rand handled it—which further supports the community element of educational programs.

So we find that at least in the areas of education in the high schools, I think we understand that you are talking about 700,000 or 800,000 young people who are dropping out of schools, and they are in many respects the greatest risk.

So we don't want to draw unrealistic conclusions, but nonetheless these results certainly give us encouragement, and we'll have a chance later to talk with the director about where this lies in terms of the priorities in the battle on substance abuse.

The importance of drug education is illustrated by these charts. Law enforcement and interdiction are crucial, but many voices—and some of the loudest are in law enforcement—are calling on the administration to recognize the importance of treatment and education. As we provide more money for this purpose, it is also important to increase accountability.

I support the administration's proposal to require the establishment of State treatment plans as a condition for each State's block grant allotment. I know that has been a combined position of the administration and this committee, and it is one that we should implement, and I will work to codify this particular requirement.

I look forward to Dr. Bennett's testimony today. I hope that he will use this occasion to endorse the goal of treatment on request and to acknowledge the importance and efficacy of drug education.

I look forward to working with him and the administration to achieve the goals that we share.

I recognize the Senator from Indiana.

Opening Statement of Senator Coats

Senator Coats. Thank you, Mr. Chairman.

Dr. Bennett, Dr. Kleber, and Mr. Carnes, we appreciate having you here and appreciate the work that you are doing in addressing America's number one domestic crisis. We thank you for your commitment.

Mr. Chairman, I would ask unanimous consent to have my full statement printed in the record, and I will just summarize a couple of points that I would like to make.

The Chairman. It will be included in its entirety.

Senator Coats. I don't think I am raising anything new to this committee when I say that the drug crisis is not just the murder and mayhem we read about in the morning paper, but it is something that has seeped into every crack and crevice of American life, whether it is urban, rural or suburban.

Dr. Bennett was in Indianapolis several months ago and heard testimony about the impact of drugs on what most people consider to be a rural part of midwest America that is sometimes inoculated from the pain and suffering that we hear about in urban cities, and he understands that that is not the case; drugs have had an impact everywhere.

When you get down to its most fundamental cause, I think we have begun to realize that we can't just deal with this problem by attacking supply alone, although I believe it is absolutely critical that the Federal Government set an absolute standard in doing everything possible to dry up supply.

But we know that the drug crisis is also a crisis that affects individuals. On the demand side, it is a crisis of individual belief and behavior, a crisis of individual motivation and action, and without that, ultimately, we are not going to be successful.

So our challenge is not to just destroy illegal substances. Our challenge is also to change minds. It is convincing individuals, especially our youth, that there is a drug-free standard that we expect and demand that they meet, while we also provide compassionate rehabilitation for those who fail to meet it.

It is also important to note, I think, that drugs don't just destroy individuals; they also destroy families. And it is my concern in this area that has drawn me to this issue over the last several years.

I think there is a broader point to be made than is often presented. Families that are fractured or do not function properly are one of the fundamental causes of drug abuse, and if we are to face the problem of addiction squarely, we must take the health of the family into account.

I think it is also important to note that we are learning that families are one of the keys to any effective program of rehabilitation. Strong families give us a fighting chance of successfully solving this problem; weak ones make our job tougher, if not impossible.

In order to focus attention on the strength of the family and the role of the family in dealing with drug addiction, I am introducing today the Family Drug Treatment Grant Program, which would provide demonstration grants that would encourage the development of comprehensive family drug treatment programs and social work follow-up for individuals in such programs.

The intent of these grants is to include family members in the treatment of individual substance abuse, recognizing that this treatment may entail the systematic treatment of the entire family. It is one thing to remove an individual from family circumstances that may be precipitating the cause of drug addiction and treat that individual, but if you send him right back into the same situation, he may be facing the same problem all over again.

There have been some successful programs that have dealt with treatment of the entire family, and I hope that this legislation I am introducing will focus some attention on that.

This is just one example of the hundreds of things that are taking place across this country—community-based programs, where communities have rolled up their sleeves and said we want to do something about this problem—and hopefully this can help.

It is important that we focus on what works, what doesn't and why. We have a great deal of money appropriated now to deal with this problem. We can't throw it indiscriminately at every program that comes along, and that is why I am urging a very careful analysis of what has taken place in this country—an objective, rational analysis of what works and what does not, and asking some tough

questions as to why it does or doesn't so that we can better target our Federal resources.

Dr. Bennett, I look forward to your testimony. I thank you for your commitment.

Mr. Chairman, I thank you for holding this hearing today.

The CHAIRMAN. Thank you very much.

[The prepared statement of Senator Coats follows:]

PREPARED STATEMENT OF SENATOR COATS

Thank you, Mr. Chairman. I commend the Chairman for convening this hearing and for continuing to pursue his interest on this important topic.

The drug crisis that this country now faces goes well-beyond the murder and mayhem we read about daily in the newspapers. Drugs have seeped into every crevice of American life—including small towns, rural communities, suburbs, and cities in my own State, as well as every State represented here today. No other problem immediately threatens our future to this degree. This drug crisis requires action on a number of fronts. We need tough law enforcement. We need higher rates of drug interdiction. We need to fight this war on drugs at every point of struggle and need.

But when you get down to its most fundamental cause, drug use will not be ended by attacking the supply-side, alone. When we speak of a drug crisis, we are really talking about a crisis of personal belief and behavior, a crisis of individual motivation and action. Our challenge is not just to destroy illegal substances; our greatest challenge is to change minds—convincing individuals, especially our youth, that there is a drug-free standard we expect and demand that they meet, while providing compassionate rehabilitation to those who fail.

The effects of drug abuse are by no means restricted to the individual addict. Plain and simple—drugs destroy families. It is this fact that drew my concern to this issue many years ago. But there is also a broader point to be made. Families that are fractured, or do not function properly, are a fundamental cause of drug abuse. If we are to face the problem of addiction squarely, we must take the health of the family into account.

Families are the key to any effective program of rehabilitation. Families are the key to tackling this problem. Strong ones will give us a fighting chance. Weak ones will make our job impossible. In order to better utilize the strengths of the family, I have recently introduced the family drug treatment grant program, which would provide demonstration grants encouraging the development of comprehensive family drug treatment programs and social work follow-up for individuals in such programs. The intent of these grants is to include family members in the treatment of individual substance abuse, recognizing that this treatment may entail the systematic treatment of the entire family.

The genesis for this legislation stems from a hearing on adolescent drug abuse held in May 1989 before the Senate Subcommittee on Children, Families, Drug, and Alcoholism. As the ranking Republican on this subcommittee, I had the privilege to invite Dr. Robert Lewis, a professor in the Department of Child Development

and Family Studies at Purdue University. Dr. Lewis testified before the subcommittee about some of the exciting results which he and his colleagues at Purdue have received from a treatment model they have developed which includes family members. A 5-year, one million dollar grant from the National Institute on Drug Abuse was the funding source for the development of this model.

To paraphase testimony given by Dr. Lewis, the treatment model helps the therapist understand an abuser's family and the environment where his abuse took place. Many treatment specialists have found such background knowledge essential when treating an addict. Too often individual substance abusers have been isolated from a major cause of their addiction. Such treatment in isolation often proves unsuccessful because, when the recovering addict is placed back into his or her family environment, the sources of tension often resurface. In short, the addict is once again exposed to the emotional stress that contributed to his or her initial drug use. The result is often a new cycle of addition and treatment.

The drug treatment family model actually brings parents, spouses, siblings, and other family members directly into the treatment of the patient. Only 10 years ago, few treatment models fully involved family members. But today, family therapy is the treatment of choice for many therapists in drug treatment. Moreover, a large body of research has been conducted substantiating the success of this approach. This research verifies what, in many ways, is common sense: The addition of one family member may directly contribute to the addiction of another. A family member may use drugs to gain attention, as is often the case where an adolescent feels neglected by his parents. Moreover, a family member may turn to drugs to escape family problems, like unemployment or domestic violence. In short, the bonds of family love can be used to work for successful drug treatment, just as family weakness can contribute to abuse.

This grant program is just one example of the many hundreds of successful approaches that local communities have themselves developed to combat drug-use and which promote a positive educational environment. In fiscal year 1991, there will be more than $300 million in new Federal funds for drug treatment. We need to provide the resources, but those resources need to go to the places that do the most good. We cannot throw money blindly and indiscriminately at the problem. We must ensure that this money is spent wisely, not only out of fiscal prudence, but more importantly because of the waste of human life which results when ineffective treatment programs continue to be used without challenge.

Mr. Chairman, I look forward to working with you as we further examine how to best fight the drug problem in our society. I am eager to hear the testimony of the Hon. William Bennett. Director Bennett's enthusiasm and leadership at the Office of Drug Control Policy has helped to prod a reluctant society into recognizing that drug abuse is a problem worth containing and eventually winning

The CHAIRMAN. Dr. Bennett, we welcome you this morning and appreciate your presence. We also welcome Dr. Kleber. I have been reading about his various publications and articles and talks; and Mr. Carnes, we are glad to have you back as well.

Dr. Bennett.

STATEMENT OF THE HONORABLE WILLIAM J. BENNETT, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY, WASHINGTON, DC; ACCOMPANIED BY DR. HERBERT KLEBER, DEPUTY DIRECTOR FOR DEMAND REDUCTION, AND BRUCE CARNES, DIRECTOR OF PLANNING AND BUDGET

Dr. BENNETT. Thank you, Senator, Mr. Chairman.

I am pleased to be here. We should probably correct these little sign boards. I am a "doctor" and Carnes is a "doctor", but given that Kleber is here, I think we can both be "misters". He is the only real doctor. If any of us get sick, Carnes and I are of no help to you; and if any of us go wacky during this hearing, Carnes and I are certainly not of any help to you. Kleber would be—unless he is the problem, which is unlikely.

In the interest of time—I know your schedule and the schedule of Senator Coats and others—let me submit my statement for the record.

The CHAIRMAN. We have announced—and we'll have other members come in, I'm sure, because this is enormously important—that we are going to have to adjourn to meet not only Dr. Bennett's schedule, who has worked out a complicated schedule to be here today, but we also have a very important ceremony at 12:00 dealing with the Holocaust, to which members have indicated a desire to go. So we will insist on the prerogative of the chair and will try and allocate the time as fairly as we can.

Just before you begin, Senator Simon, is there any opening comment that you want to make? Dr. Bennett was just getting started.

Senator SIMON. I would simply say that this whole area of education and treatment is an area that we have not paid enough attention to. Over and over again as I talk to the law enforcement people, they just hit that. The number one thing, when you talk to law enforcement people, is education, just overwhelmingly.

I just had a hearing in Illinois last week, and it was the same thing. And along with that, treatment, so we can reach people who are addicts and get help for them right away.

I have no formal statement, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I would recognize Senator Harkin. Dr. Bennett was just getting started, and I apologize for interrupting.

Senator HARKIN. No, Mr. Chairman. I am sorry I'm late, and I have no opening Statement.

The CHAIRMAN. OK.

Senator Kassebaum.

Senator KASSEBAUM. I have no statement, Mr. Chairman.

The CHAIRMAN. OK. Please proceed.

Dr. BENNETT. First of all, I agree—if people are not talking about the importance of treatment and education, they should be, because they are very important parts of it. We feel that the emphasis we put on treatment and education in the strategy, and the support that the President has given to these areas, makes us very comfortable with our view on it.

I find myself talking a great deal, as you noted in your comments, about law enforcement not so much because we believe it is the only way or the principal way, but because we find ourselves

criticized by people who agree that treatment and education are important, but who attack the idea of law enforcement, so we find ourselves in the position of needing to defend that.

There are a lot of people in favor of legalization and those sympathetic to some of the ideas of legalization who attack law enforcement, so we have to spend a lot of time defending that. But that doesn't mean that education and treatment aren't very important to us; they are, and I think that evidence is in our strategy and in our budget.

Second, I think there are large areas of agreement between us, Mr. Chairman. I am very pleased about your endorsement of the State treatment plans and for accountability in this. I think if there is anything we need right now in our legislative package, it is that, and I am pleased that you are supportive of that.

We've got a lot of interest in treatment out there; we've got a lot of people who want to provide treatment. There are a lot of people getting into the business now, seeing it as something good to do and as something on which they can find some money to do. We have to be sure that we have good treatment, accountable treatment, and we think these State treatment plans as a condition of receipt of Federal funds is an excellent idea, and we are pleased you are endorsing that.

Second, we think our national drug strategy doesn't lack balance. We think it is a good and balanced approach, and we are happy that it is. We talk in the strategy and put up the funds in the strategy to make a serious attempt at all fronts.

You are quite right to talk about the 70-30 split. In our request for fiscal 1991, this 70-30 split, of course, is exactly what the Congress appropriated in fiscal 1990, so we are not alone in our recommendation of 70-30. Some things cost more than other things. The Congress recognizes that, we recognize that, and we are glad to have the company of the Congress with us on that. We don't think we should be criticized for this unless Congress wishes to criticize itself for its own actions in this regard.

In terms of education, I do not belittle the importance of drug education. I simply don't think it is a magic bullet. The last time you and I spoke about this was I think what gave rise to this notion about the belittling.

The comment to which I was responding was the notion that we could somehow find some course or courses that would inoculate young people against drug abuse. There is no such course or courses. If we found a course to inoculate young people against drug abuse, we should simply find a similar course that will inoculate them against cowardice, stealing, alcoholism, and a whole range of things, and give them that same course.

If ignorance is the problem, knowledge is the cure, but when it comes to drugs, often it is not knowledge that is the problem; it is something else.

In any case, we believe that a concerted effort in the schools, both in terms of programs and in policy, can make a great deal of difference, and that is something we stand by.

Why don't I stop there. I would just mention at the beginning that in the last year since I have been appointed to this job, I have been to about 25 treatment programs, treatment centers, and spent

a lot of time in them, watching them and observing them. And I am very impressed at the work that is done at a number of America's treatment programs. There is a real difference; there are real differences in quality, as one finds in American schools or any other American institution. Thus again the importance of the accountability provisions.

Let me leave it at that and welcome your questions.

[The prepared statement of Dr. Bennett follows:]

PREPARED STATEMENT OF DR. BENNETT

Mr. Chairman, a few months ago *The New York Times* editorialized that in the drug war there has been a victory over confusion; among Republicans and Democrats alike there is broad agreement that we must push on all sides of this problem at the same time. We agree that we cannot rely on any one element of our drug policy, since effective policies to reduce demand and supply are inseparable. Without effective treatment and prevention, our criminal justice system will be overwhelmed. And unless we are successful in making drugs less readily available and our streets more secure, treatment and prevention will accomplish very little.

Because we regard demand reduction as an essential component of a successful drug control strategy, the administration is seeking nearly $3 billion for demand reduction activities in FY 1991, an increase of $1.2 billion (or 75 percent) from the FY 1989 level, just before President Bush issued the first Drug Strategy. The goals for these efforts are straightforward: To get those currently using drugs to stop, and to help those who haven't used drugs never to start. The President's National Strategy describes a number of policies and initiatives for demand reduction, and I would like to highlight just a few.

Preventing the use of drugs means rendering their use intolerable in the minds of all Americans through the use of education, moral suasion, and clear consequences for drug use. Schools have a vital role to play in prevention, and the Strategy recognizes it by seeking nearly $600 million for drug education programs, primarily in elementary and secondary schools.

As William Raspberry has observed, however, education is the solution only insofar as ignorance is the problem. Researchers tell us that simply providing kids with well-packaged information on drugs does not deter use and can even serve to pique curiosity about them. And we also know that the mere telling of drug horror stories will not counteract youthful notions of invulnerability.

But well conceived education programs can and do work, especially those that make clear that using drugs is wrong, harmful, and dangerous, and that give young people the skills with which to resist peer pressure to take drugs. We also know that drug education has much greater effect on student behavior if bolstered by an unambiguous school policy that drug use will not be tolerated. We are very pleased that the Congress has passed legislation, proposed in the first Strategy, requiring all schools and colleges to develop and implement drug policies and programs or face the possible loss of Federal funding. This will help a great deal.

A clear no-use message at school is sustained best when it extends beyond the schoolyard. Students are surrounded every day by forces and circumstances that are beyond the reach of teachers and principals, so school prevention programs must constantly be reinforced by all parts of the community: Churches, civic groups, local government, the media, and law enforcement. And let's not forget parents—the first line of defense. The Department of Education recently issued a very fine handbook for parents who want to keep their children drug-free.

Our Strategy recognizes that effective prevention demands that the entire community—including the schools—be mobilized. Strategy I called for the creation of a new community partnership program to help communities band together for prevention, and I'm pleased to report that the call for proposals was issued last month. We propose to double the program's funding in FY 1991.

Because families who live in the Nation's public housing projects suffer disproportionately from the lawlessness and misery of drug trafficking and use, we have greatly expanded the Department of Housing and Urban Development's Drug Elimination grant program. The first grants were recently awarded, and an additional $52 million is being sought for next year. These and other community initiatives, both public and private, recognize that civic courage, when united with thoughtful planning, is the best weapon in the war against drugs.

For a majority of people who have become addicted to drugs, treatment is crucial, and the President's National Strategy contains concrete proposals to increase treatment capacity and markedly improve the effectiveness of the Nation's drug treatment system.

First, the capacity issue. The majority of drug addicts are employed and between 18 and 40 years of age. Many of these people can be treated at private treatment centers which are, on average, only 55 percent full. But our public facilities are filled to near capacity, and there are long waiting lists for some programs. Moreover, drug treatment in our correctional facilities, among whose inmates there are large numbers of drug addicts, is far from adequate.

Federal, State, and local authorities are working steadfastly to expand the availability of treatment, especially for those priority populations identified in the National Strategy: pregnant addicts, adolescents, and prison inmates. The President's budget request would provide 68 percent more Federal money for treatment than was available when he took office. These new funds will begin to bring the supply of publicly-funded treatment more in line with the number of addicts who need it. I would hope that the States will follow the Federal lead and expand their own support for drug treatment.

But expanding treatment capacity does nothing by itself to address the need to improve the quality that treatment. Whether we are talking about the vexing problem of the "revolving door"—addicts repeatedly and impulsively entering and dropping out of programs, or about a shortage of trained staff, treatment sites, or accountability for results, there is much to be done if we are to have a drug treatment system capable over the long term of helping addicts take responsibility for ending their dependence on drugs.

With such an overriding need to improve the effectiveness of the drug treatment system, I was disappointed by the failure of Congress to enact the President's legislation requiring statewide treatment plans. These plans would instill much-needed accountability into the nation's treatment system, and would require a comprehensive State planning effort to identify and meet the State's treatment needs. Congress has appropriated significant resources to drug treatment in the past year. Our amendment would help ensure that funds are spent in the most effective manner and targeted on individuals in greatest need.

One of the most important Federal roles is improving drug treatment is the support of promising new models and methods, and basic and applied research. In treatment as well as in prevention, we must learn more about what works. In the next fiscal year, for example, HHS will be supporting a number of treatment campus demonstration projects that will use centralized referral, and offer a variety of treatment modalities.

Developing effective treatment and outreach methods for pregnant addicts and their drug-impaired infants is a major priority of the Strategy. This year, OSAP will spend $32 million on outreach and prevention projects, and NIDA will spend $46 million on research and demonstrations. We propose to increase these efforts in the next fiscal year.

In other research areas, we propose to expand efforts to develop and test pharmacologic treatments for drug addiction through a new medications development unit in NIDA. We need better information about who is using drugs, how frequently, how many are receiving treatment, and how effective that treatment is. To improve our epidemiologic data collection, particularly the Household Survey, we are seeking a 30 percent increase in funding next year.

I appreciate this opportunity to discuss the administration's demand reduction strategy, and I would be happy now to respond to your questions.

The CHAIRMAN. Fine. We'll try and keep to 10-minute rounds for questioning, and I'll ask staff to keep the time.

The two areas I wanted to get into, which I indicated to you just briefly before the hearing, are on the treatment aspects and also with regard to the need.

Trying to use the administration's or NIDA's figures on the current situation, and I think we have to recognize that all of these figures are reasonably soft, and I don't question that. I think the American families and communities know we've got serious problems. My own sense is that the State offices can probably give us the most accurate information on what is really happening out in the various communities.

The best estimate we've been able to get of the number of drug addicts is at least 6 million, and some recent studies indicate that it may be higher. As I understand, your strategy is that 25 percent of the addicts will not benefit from treatment, and 25 percent can overcome the addiction without treatment; therefore, about 3 million would benefit from treatment.

The current treatment system serves about 834,000, according to your own strategy, but only 518,000, according to NASADAD, or States.

In any event, the administration proposes to increase block grant funding by $100 million, which would generate 11,000 Federal treatment slots, which is 28,000 patients. The administration strategy actually cuts demonstration grants—for example, no funding for waiting list reduction grants—resulting in a net increase of only 4,000 Federal treatment slots, or 10,000 patients.

So even if matched by the increase in State and local funding—and I think all of us are very much aware of the extraordinary pressures that are on State and local and many regions of the country—the new money adds up to only 62,000 patients, effectively.

So with no new funding, the administration claims a total U.S. capacity of about 600,000 treatment slots. Even assuming the higher estimates, the total capacity only serves about 1.6 million patients, well short of the 3 million addicts who could benefit from the treatment if available.

Then with regard to the waiting lists, our best information is that NASADAD, in their 1989 survey, found that over 66,000 people were on the drug treatment waiting lists on a given day. One-half had been on for longer than 30 days; average number of days were 21 days for outpatient, 43 days for inpatient. I think there is a general awareness by those who follow the situation that these surveys underestimate the magnitude of the problem.

So given the very limited numbers of the increases, and given the significance in terms of the problem, and given the alternative that it is either incarceration or treatment, what can you say to those who are out on the front lines in terms of trying to deal with the problems of treatment and the kind of support that they are going to receive from the national strategy?

Dr. BENNETT. Well, agreeing with you that nobody has numbers as hard as we'd like to have in this area, our assessments and our numbers are in fact quite different.

Dr. Kleber, could you speak to that?

Dr. KLEBER. Yes. Using the household survey numbers, NIDA estimated that there were roughly 4 million individuals who had used illegal drugs 200 times or more during the past year. So that figure comes up to 4 million rather than 6 million.

I would agree that that number is probably low, that given the inadequacies of the household survey, which we addressed in Strategy I and which we have taken steps to remedy, the number is probably somewhere between the 4 million which that survey suggests and the 6 million that you have just given. Exactly where between those two numbers, I think would be a matter of sheer guessing.

In terms of the waiting lists, there was about $100 million in waiting list money. The applications for it were only about $120 million. So there was not a large discrepancy of demand out there for waiting list money that wasn't being filled by that.

We feel that, yes, there is a need for treatment out there, but the way to go is by increasing the block grants rather than by increasing the waiting list grants.

The CHAIRMAN. Well, do you support—as part of the national strategy, dealing with all who are on any waiting lists? Where do you come out on the question of trying to deal with any individual, as part of the national strategy, whether through Federal legislation or through the block grant, for any individual who has this affliction and needs help and wants help? As a part of our national strategy we are going to patch together sufficient resources at the national, State and Federal level to make sure it is going to be available to them at some period of time?

Dr. BENNETT. Yes, I think our view is at least very close to that. Anybody who wants and needs treatment and who we believe can benefit from it and who is serious about treatment—this is not just a bad crash from drugs, but is serious about it—yes, we should work toward developing a capacity to provide treatment for such people, recognizing the range of possible programs—Federal, State, local, private and so on; yes.

The CHAIRMAN. Just so I understand now as clearly as I can, with regard to treatment—we have the situation in prisons, for example, where we have seen a reduction in terms of support for treatment of those who are incarcerated. And yet we have also found a record that even those individuals who are incarcerated who get treatment, that there is still a positive result, even though they were unwilling to go into it.

Now, I don't want to confuse the first question with the second one. But for those who desire and want help and assistance, do I understand that part of the national strategy is to make sure they are going to get it, and that part of the national strategy is to work either at the national, State or local level to ensure that we are going to have programs so that help will be available.

Dr. BENNETT. Yes. Again, national, State, local, private—all the sources, all the supplier of treatment, recognizing a whole range of institutions here from religious institutions to medical institutions. We should be in a position, as a matter of our national interest of protecting our society as well as trying to help people, to provide assistance to people who genuinely need, want, and are prepared to take the steps to help themselves in treatment.

The CHAIRMAN. Do you want to make a brief comment with regard to those in prison? We have seen a reduction with treatment in terms of those in prison. We know that in cities like Boston, Philadelphia, New York, probably 90 percent of those arrested test positive—the national average is about 50 percent—but generally, in areas of highest incidence of crime, that they have the problems. And yet we have seen a reduction in terms of Federal support of effective programs. What can you tell us about that?

Mr. CARNES. Thank you, Mr. Chairman.

Yes, we agree with you on that point that those who are incarcerated in many cases need treatment, and we should make that

available. And in 1991, we are providing $142 million that we can identify right now that would go for treatment of those who are incarcerated.

I would make one final point on that. As part of the Statewide treatment program in connection with the ADAMHA block grant, we believe that States should have to consider the treatment needs in their own State prisons and jails and look at that in preparing their treatment plans so that those funds could be used in State facilities if necessary. Typically, the treatment system does not use much of their funds in that area, and we think they should look more at that.

The CHAIRMAN. Well, as I understand, the Office of Justice Programs has eliminated all the discretionary funds for development of programs in prisons. Are you familiar with that?

Mr. CARNES. We are putting an increasing emphasis on the provision of treatment through HHS for individuals in prisons and in jails. The Bureau of Justice Assistance block grant will still provide, in our estimate for 1991, $105 million that would be used for that purpose. So the principal money from the Justice Department for this is the block grant rather than the discretionary funds.

The CHAIRMAN. The bottom line is that you believe the way it has been worked out with the administration—just so we can follow this over the period of the budget appropriations—is that there will be more funding in terms of support for programs in prisons to deal with this problem?

Mr. CARNES. Yes, we do, and we think that the States should also take a hard look at that.

The CHAIRMAN. OK.

Dr. BENNETT. Could I just add to that, Senator?

The CHAIRMAN. Yes.

Dr. BENNETT. Whatever our differences—and I think there are some, but not many—part of our legislative proposal, as you know, refers to a phrase called "maintenance of effort". We have got to be sure that as we look at the Federal budget and the national strategy and propose more money into treatment programs that the States maintain their level of effort, because we've gotten some disquieting reports of States taking the Federal money and then closing down their accounts, so that the Federal money supplants, not supplements, the State effort.

If we increase but they eliminate, we're going to be where we were.

The CHAIRMAN. Well, I don't think you'd find a difference on that in terms of this committee. We have run into that in other areas. I think the question is whether we set up the kinds of matching programs which make it virtually impossible for communities and States to recognize it in a time of tight budgets.

Let me move on, if I could, to the area of education, Mr. Bennett. When we talked about this at an earlier hearing, you had a response about the role of education. You said: "Should we have drug education programs or should we have tough policy? If I have the choice of only one, I'll take policy every time, because I know children." Later, you grudgingly called drug education "a helpful auxiliary".

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Now, in a book that was written with regard to schools without drugs, there is this quote: "Schools are uniquely situated to be part of the solution to student drug use. Children spend much of their time in school. Furthermore, schools along with families and religious institutions, are a major influence in transmitting ideals and standards of right and wrong. Thus, although the problems of drug use extend far beyond the schools, it is critical that our offensive on drugs center in the schools." That is Bill Bennett.

Dr. BENNETT. Yes, sir.

The CHAIRMAN. Will the real Bill Bennett stand up? I think there is, both by response to questions and by emphasis and statements, some question, I believe, probably in the minds of the committees and Congress and across the country.

Dr. BENNETT. I believe it. Again, what I don't believe is that we can inoculate children against drug use. But I believe in good, sound education programs, conjoined with good school policy.

And happily, Senator, we do not have to choose between sound school policy and good pedagogical programs. We can and should do both, but we must do both. I have just run into this too many times. A good drug education program and a lax policy, what the kids read there is hypocrisy. You've got to have both.

The CHAIRMAN. Well, I think you'd agree with me that the programs which have been most essential and most effective have included churches, businesses, sports programs. I am always amazed that this is one city in the country that doesn't have a little league program—not that that is the answer, but I think it is a variety of different programs that support. And if you look at the areas—Kansas City, Seattle—in the Rand studies, which have brought the combination of those elements, plus effective education programs—it is basically talking about $25 per student, half of that in terms of the education programs, the other half in terms of support for community-based organizations. And if you spread that out across the country for 40 million students, you are talking about $1 billion, and that does not reach out to the kinds of students who are at greatest risk in terms of those who are dropping out.

But it seems to me we can have the kind of results that we have had over there. My time is up, but I am sure you have had the opportunity to read that Rand study and report. I think it makes a very, very powerful case on this issue.

Dr. BENNETT. We have read it, yes, sir.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

I would like to continue on with the education issue for a moment, because I very much agree with your observations. I have spent a fair amount of time in Kansas visiting those elementary/secondary education classrooms and asking students about the various programs. I have come to the conclusion—totally unscientific—that the programs that really are working best in this area are the ones that are for the younger children; that if you being drug education much beyond elementary, it really is lost.

In your review of programs that are working or not working, do you have any statistics supporting this notion?

Dr. BENNETT. I think you certainly have a more captive and interested audience. The evidence we have is that there are a whole array of school education programs, many of which can work.

One of the critical things that enters into—and I don't want to get into a long speech about this—particularly when you get to the middle school grades is peer pressure, and I think everybody knows that.

To the degree that we can influence peer pressure, we can really have a very positive effect.

I am impressed—let me just make a comment here, sort of a direction for things we might look at—I am impressed with the number of programs I have looked at in which student leaders, if you will, the contemporary role models, the kids who are looked up to by the other kids, are given intensive effort by principals and counselors in the schools to have a clear anti-drug message, to act in certain ways and to encourage their peers to act in certain ways. This seems to be a very promising area.

For the difficult ages, 12, 13, 14, you are right, Senator—I think every parent knows this—that at 5 or 6 or 7, in some ways, kids are more pliable, but the temptations often are not there at those ages.

Senator KASSEBAUM. I agree. And I think the middle years are terribly important. But I found that with high schools students, you're not really telling them anything they don't know.

Dr. BENNETT. That's right.

Senator KASSEBAUM. And I think that is where your point about the whole atmosphere is extremely important. It isn't just the drug program or the material in the classrooms in isolation.

Dr. BENNETT. The *Wall Street Journal* had a story about a very affluent high school in the State of Washington—and I note Senator Adams is here—that had won awards for exemplary drug education programs. The problem is that on weekends, the affluent student body boozed up and took lots of drugs because there wasn't any policy. It had the best, gold-plated drug education program in the State of Washington, but there wasn't any policy, so the kids knew that if they used drugs no one was going to penalize them. You've got to have both.

Senator Adams. Would the Senator yield for a comment, since there has been a comment about the State of Washington?

Senator KASSEBAUM. Yes.

Senator ADAMS. I visited those schools, Mr. Bennett, and the thing they are doing, and why we are concerned about the amount of money that is going out—and I was very concerned about your statement of nonsubstitution of State projects—I visited those schools, and what the Senator is saying is absolutely right; it is a 4th, 5th, 6th grade program where the deputy sheriff goes into the classroom and actually instructs, and the children take all of this home. But the problem that they have is that that pulls the deputy sheriffs off the streets—and this is in Snohomish and Marysville and elsewhere—and they need the money to put another person back on the street so the deputy sheriff can be out.

We are trying to spread this throughout the State, and we are being successful, but there is no money flowing down yet.

So we have the second problem that in the rural communities like Yakima, the drugs are flowing in, and that is why I am hopeful that you will be persuasive in the administration in helping us pass Senator Biden's and my program of $300 million where communities can ask for disaster relief to do the thing that you are talking about, which is to be able to deal with their treatment problems of the people they have to put on the streets while they're trying to pull them out to go to give the treatment.

I thank you very much for yielding, Senator Kassebaum.

Senator KASSEBAUM. You are certainly welcome. I'm not sure I was speaking about a lot more money, but——

Senator ADAMS. Well, not a lot more, but just a little.

Dr. BENNETT. Well, let me comment, because Yakima is one place, but Bainbridge is another. And Bainbridge may be short on a lot of things, but they are not short on cash.

Senator ADAMS. But Yakima is.

Dr. BENNETT. Yakima is. But Bainbridge's problem isn't cash.

Senator ADAMS. Thank you very much.

Dr. BENNETT. Let's go back to Wichita.

Senator KASSEBAUM. Well, I'm not going to analyze it, but I think the point of these observations is to analyze what is working and not working, and share that information—which I think you are attempting to do, and that's a large task—so that there is a better understanding of programs like the drug-free school program; what works, what doesn't work, where the emphasis should be. I think that is what I was hoping, that more of that analysis could be shared.

Dr. BENNETT. We are doing that kind of review and assessment. My own personal feeling—and I'd like to say something in support of what Senator Adams added to this—is that these programs for young children in which the police officer and the sheriffs are there, the DARE programs, are very, very good programs.

Senator KASSEBAUM. Yes, they are.

Dr. BENNETT. It is that first relationship with a policeman being a friendly one rather than having him cuff you on the back of the neck that I think is one of the very positive things.

Senator KASSEBAUM. And I think a lot of the community usually turns out, and they have their award ceremonies and so forth.

Dr. BENNETT. That's right. It fulfills that notion of involving more of the community; it is not just the teacher, it is the police officer coming in.

Senator KASSEBAUM. Before my time is up, I'd like to go back to law enforcement and rehabilitation, because I am worried about moneys going back to the States in this particular relationship.

True, I certainly am supportive of the President's initiative on State treatment plans and think that is an important initiative and I hope the States maintain their level of support. But on the other hand, a number of States are really strapped, I believe, for expansion of facilities—prison facilities particularly—where I think there has to be some different approach for first-time offenders, for instance, that can combine tough rehabilitation and law enforcement. That requires a lot of money and trained personnel, which most States simply don't have right now.

How do we better balance what I believe are those important needs?

Dr. BENNETT. I agree with you. I think you are right. I think the kind of flexibility that we recommend in the grants is one way. What we have learned is that there are lots of better ways to take care of that first-time offender in many cases than simply incarcerating them, and we are strongly in favor of alternatives.

A number of programs that we have seen and are impressed with provide the opportunity for that first-time drug offender to avoid imprisonment by going into a treatment program and successfully completing the treatment program. That gets you into the other, grants coming to the States. But I think that we need to see these things in combination and in cooperation, rather than, if you will, an array of single slots.

Senator KASSEBAUM. Is that coming, do you think?

Dr. BENNETT. I think so. Again, part of our assessment of what works is pointing us in that direction. The most singly impressive program I have seen in the country along these lines is in Maricopa County in Phoenix. Now, they are very tough out there. Marijuana possession is a felony. But you don't get charged with a felony if you get arrested if you go into the treatment program and successfully complete it. Unless you are indigent, you have to pay for that treatment program, so it doesn't cost the State anything, and it doesn't cost the Feds anything. The person who uses illegal drugs ends up paying for his own treatment, unless indigent. This is a sound program that has returned about $400,000 to the county treasury and I think is a kind of breakthrough program. This is the kind of thing other States need to be looking at.

Senator KASSEBAUM. Well, one of the things I hear most out home regarding incarceration and treatment is that it just becomes a revolving door—people go in and they go out, first because there is no room, and second, there is no money for rehabilitation as well as incarceration.

Dr. BENNETT. Well, the money has increased, as you know, dramatically, about 70 percent since 1989, both for treatment, and my guess is that money will continue to come. But again, we have got to be smarter and more imaginative and not just think of it as separate blocks, with incarceration over here and treatment over here. We must see the things as related.

Senator KASSEBAUM. The difficulty that States are having is they don't have the funds, either, and maybe that is part of the whole Statewide treatment plan that has to be developed.

Dr. BENNETT. That's part of it. Frankly, some of the States we have seen, Senator, are reluctant to do what has to be done. I mean, they don't want to build prisons because they are expensive. They don't want to provide additional treatment slots. But I think this treatment accountability is a very important part of this.

When I was in Wichita—if you remember my visit there—we talked to a 14 year-old boy in one of the treatment programs. This was his fifth bout at treatment. Now, Dr. Kleber will tell us lots of people do not make it the first time because it is very hard. But if you think about all the unsuccessful efforts we have and the expenditure of funds for unsuccessful efforts, we should be doing a lot better; I agree with you.

Senator KASSEBAUM. I would like to follow up, then, and ask Dr. Kleber a question because I believe in your confirmation hearing you mentioned that research would be a top priority. It certainly is something that you know very well. Have you had the opportunity to focus on some in-depth research on what is working and what isn't working and the priorities that we should be setting?

Dr. KLEBER. One of the salutary things that emerged in the fall from Strategy I was HHS setting up the Office for Treatment Improvement, and they are going to be working to put out treatment demonstrations, to try and figure out which models work best. For example, in the area of pregnant addicts, there is no question we have a major need there. It is also very clear that we don't really know what is the best way to treat these pregnant addicts. So the Office of Substance Use Prevention and the Office for Treatment Improvement will be looking at how are we going to come up with better models for the pregnant addict. And of course the Medication Development Program that NIDA is pushing is trying to come up with better medications to treat addicts.

So these are some of the kinds of research that is going on now, and that we have asked for substantial increase in research funds, as well as funds for OTI, and we think that will help us figure out what works best for treatment.

Senator KASSEBAUM. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Harkin?

Senator HARKIN. Thank you, Mr. Chairman.

Dr. Bennett, I just want to associate myself with what Senator Kassebaum said about getting these kids early on in school rather than waiting until later, and taking off from what you said about inoculating kids, that you can't inoculate against drugs; it is like inoculating them against cowardice, stealing, lying—and you had some other ones, and I was writing them down as fast as I could. And you said it is not a lack of knowledge; it is something else. It is not a lack of knowledge; it is something else.

There is a program that started in the Des Moines schools a couple of years ago, and they just dubbed it "Smoother Sailing". Actually, it was started by the private sector who put money into it, businesses and McDonald's. It was designed to run an experiment, Senator Kassebaum, on decreasing the number of students per counselor in grade school, in kindergarten, 1st, 2nd, 3rd, up to middle school.

The national average for counselors now is about one counselor for 1,200 kids. They reduce it to one for 200, I believe. So they went out and hired a whole bunch of counselors. The counselor is in that school every day, all day long.

I visited a couple of these schools where they have the counselors, and when the kids come in to school the first thing in the morning, the first person they see is the counselor, standing at the door. And then during the day the counselor will go around, take certain kids out of class, take them into a special room, where this counselor will counsel the kids, and they go through a program, they have teaching materials.

It is not specifically designed just to say "Say no to drugs"; it is a whole curriculum on self-esteem building, talking about the prob-

lems they have out of school, at home; the counselor even pays home visits with the kids at their homes.

It has now completed its second year, and you ought to talk to the people in the Des Moines school system; they love it. They think it is the best thing that has ever happened.

Now, can you longitudinally show that there has been a decrease in drugs? No. These are kindergarten, 1st, 2nd and 3rd grade kids. But what they can show is that these kids' grades have gone up; their incidence of stealing has gone down; the days missed from school have gone down; the number of fights and problems they get into in school has dropped precipitously. And a lot of these kids come from really bad homes.

Sometimes, I listen to people talk about kids in school and the drug problem, and I get the idea that everybody thinks all these kids come from families like Ozzie and Harriet Nelson's, or the Huxtables, that that is where everybody comes from. Some of these kinds have really bad homes. They have a parent in the penitentiary, another one taking drugs, they were being abused. This is what they see.

So I tell you that because even though you can't inoculate them——

Dr. BENNETT. No; I understand what you're saying, certainly.

Senator HARKIN [continuing.] But what you can do is start at that early age——

Dr. BENNETT. You can love them and teach them.

Senator HARKIN. That's right, and that's what these counselors do. And the teachers love them, because what the teachers have said all along is, "You know, we spend half our time being a surrogate parent rather than teaching."

Dr. BENNETT. That's right.

Senator HARKIN. Now the counselor does it. The counselor is equipped to do that. They spend all their time doing that.

I can't tell you, seeing the looks of these kids when they come into that school in the morning, and the first person they see is that counselor. It is like the Rock of Gibraltar.

Now, it seems to me, intuitively—I can't show you that we've decreased any drug use—but intuitively, I've got to believe that this is going to have a long-term effect.

Dr. BENNETT. Yes.

Senator HARKIN. What can you do to help to promote this kind of reduction in ratio of counselors to students in grade schools—I think it fits in exactly with what you were talking about, Senator Kassebaum, and that is getting these kids early on in life, in kindergarten, 1st, 2nd and 3rd grades.

I don't know if you have ever taken a look at the program out there or not; I commend it to you highly to take a look at it.

Dr. BENNETT. Right. Well, I think it is the sort of thing we probably spent more time on when I was at Education. I think their description is right, a kind of surrogate parent.

Children do not raise themselves. They need to be raised, they need love and order. That seems to me what these good people in the Des Moines schools do, is provide love and order.

As a question of public policy, do we have enough counselors in the world to provide all the love and order for all the children who

need it, and do we decide as a matter of public policy that it will be counselors raising children rather than families—I don't mean to suggest which way we come out on this, but we can as a society decide to turn over the raising of our children to people other than their parents.

Senator HARKIN. Well, wait—let's recognize reality for what it is. I mean, these kids don't have a family; they do not have parents.

Dr. BENNETT. I know, I know. But I think we need to act in public policy in a way that suggests greater burdens and obligations for parents.

Senator HARKIN. Well, that's fine, but these kids, their parents—one is in prison and the other one is doing drugs; they are being abused—I mean, in theory, you are fine, but that's not the real world out there.

Dr. BENNETT. No, I know. I understand the real world. But when it is broken, of course you have to provide for the child. But before it breaks, I think we should do everything we can to get that family back in shape, because it is still a surrogate parent; it is still a surrogate parent. And what does this mean? This means the prosaic business of making sure that dads don't run off, that they pay for the support of their children, that people are hauled into court the first time, that there are serious penalties for child abuse and all these kinds of things. We let bad parents get away with murder in this society.

Senator HARKIN. I agree. But let's quit trying to patch it up, and let's look at the next generation. Maybe the next generation will have better values and be better able to resist drugs if you start with them early on and have the counseling.

Dr. BENNETT. That's fine, that's okay. That's fair.

Senator HARKIN. What I'm saying is that I wish you would look at that——

Dr. BENNETT. Sure.

Senator HARKIN [continuing.] And take a look at that kind of a program and see how much money we could put into it for the counseling, especially in areas of high risk, where students are at risk in certain areas.

Dr. KLEBER. Senator, I would just like to also comment that there is a very interesting program in New Haven, Dr. James Comer's program, where he took some of the worst inner city schools, and by involving what parents there were, managed to turn a couple of the worst schools in New Haven into some of the better ones. That has now been adapted to over 50 schools across the country.

So there are a number of different models of ways that you can intervene in the primary school level to try and improve things. I think the Des Moines model is certainly one that should be looked at. I think Jim Comer's model is another that we need to look at very seriously.

Senator HARKIN. That's great. Let's get those things spun off around the country. Again, it is going to require—I'm talking about hiring counselors—it will cost money.

There are two other areas I wanted to cover very briefly in regard to treatment. We have a four- to six-week waiting period in Iowa for treatment. Do you have any idea what it would cost if we

were to have treatment on demand throughout the United States, so that someone who came in for treatment could get treatment right there?

Dr. BENNETT. Bruce, you may comment. What we are trying to work toward, Senator, is to be able through the capacity of Federal support, State support, local support, private support, etc., to provide the opportunity for anybody who wants treatment and who can benefit from it and will approach it seriously to have it, and we think the amounts of money that we are talking about for a request for fiscal 1991 is getting us close to that capacity and that amount.

Mr. CARNES. Senator, we are requesting $1.5 billion for drug treatment in fiscal year 1991, and our estimate is that that would provide treatment over the course of the year for approximately 1.7 million people.

Now, depending upon what number of people you want to provide treatment for, you can do the multiplication yourself. That basis is those individuals who have serious drug problems, who can benefit from treatment and who want it.

If you were to provide treatment on demand for everybody who uses drugs, you are looking at a multiple here of four or five times that, plus you would have to fund a number of vacant slots that you wouldn't have used so that there would be vacant slots available for people should they come in. So that's part of what treatment on demand means.

Now, we think that we have got a proposal here—we have increased it about 70 percent in the last couple of years, and we project that it is going to continue to increase, and we are going to keep moving to provide more and more of those treatment slots. I don't know that we'll ever hit a time when we can provide a slot for anybody who should come in anywhere in the United States at any moment and say, "I want treatment," for whatever reason, "right now."

Senator HARKIN. So you say it's not possible.

Mr. CARNES. I say if it is possible, it is going to cost many, many billions of dollars.

Dr. BENNETT. No. What he said is anybody coming in at any part of the country at any point in time, any time, day or night. That suggests treatment centers as prevalent as 7-Elevens.

Mr. CARNES. Right.

Dr. BENNETT. That is not going to happen. But can you dramatically increase your capacity so as to take care of people in a reasonable way—they may have to go across town or may have to go down the road a bit—sure. And I think we are gradually getting there.

Senator HARKIN. When can we reduce that waiting time down to 1 day rather than four to 6 weeks?

Dr. BENNETT. Well, I think it depends on the place you are talking about, but I think the time can be reduced. It is a complicated matter in regard to treatment accountability here. The problem with the notion of treatment on demand, apart from the question of who is in charge here, is that many people will seek out treatment which is not the best for them. You may have long lines for

some programs, while at other places there is capacity, and nobody is using it, because of the different nature of the program.

We see this all over the country. It's like two movie theaters, and one of them has a long waiting line, and the other one, half the seats are empty—a perfectly good movie—in fact, maybe a more demanding movie than the first one, and that is why the line isn't as long.

So you've got to get those problems sorted out, too. But I think things are improving and will continue to improve.

Dr. Kleber.

Dr. KLEBER. I think part of the problem in estimating what is happening with the treatment system now is that there is a very large increase in funds that Congress appropriated that is just now hitting the treatment system. And I agree, four to 6 weeks is too long and should not be happening. What happens when all that 1990 money is spent will be interesting to see at the end of 1990 and into 1991, how long these waiting lists are going to be.

What I hear from some of my colleagues in the field is that although there are still going to be many people out there who are addicts who need treatment, that as the system markedly expands, unless we have ways of making sure these individuals remain in treatment, you may find by the end of 91 that the treatment system has vacancies. I'd like to see that happen because I'd rather have some of that than have these long waiting lists. But I think ideally what we need is a middle ground where we have an adequate treatment system that is working, that has evaluation built in; when people come, they don't just get treatment whatever door they happen to knock on, but they are assigned to appropriate treatment, depending on their needs.

Senator HARKIN. Mr. Secretary, just one last thing. Last year when you were in Iowa, I know I caught your attention when I pointed out that the National Guard—this is outside of the area of treatment—but the National Guard was flying helicopters to identify, and it was costing them $648 an hour to do that, but the Civil Air Patrol was doing it for $41 an hour and doing it a lot better.

Dr. BENNETT. Yes, I remember that.

Senator HARKIN. You were going to follow up on that. It call comes out of the same thing——

Dr. BENNETT. I know, and I remember that.

Senator HARKIN. But I'm telling you we are missing a good bet here——

Dr. BENNETT. Greater involvement of the CAP; yes, sir.

Senator HARKIN [continuing.] And I hope you'll look at that again.

Dr. BENNETT. We sure will, we sure will. Thank you, Senator.

Senator HARKIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Just to underline what Senator Harkin has pointed out, I don't know how people stay on any waiting list if they are afflicted with this scourge of drug addiction if they are not able to get some kind of immediate attention. It is difficult for me to believe that they are going to come in every day or every other day and stay on it. It is just so inconsistent, and there are obviously going to be failure. The enormous inconsistency has been point-

ed out by Dr. Kleber in his article in the *New York Times*. We have got short lists in the private, and long waiting lists in the public. But I don't know what good it does to have a slot at Betty Ford when you are a drug addict in New York City. That is the kind of dichotomy that we are facing on this thing today.

I notice my colleague and friend, Senator Thurmond——

Senator THURMOND. Mr. Chairman, would you give me about 2 minutes to make an opening statement?

The CHAIRMAN. I am glad to proceed in whatever way the ranking minority member wishes to proceed.

Senator HATCH. That's fine.

The CHAIRMAN. And I think it is fine with the Senator from Indiana and the Senator from Minnesota.

Senator COATS. Absolutely.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Thank you. Mr. Chairman, I'd like to commend you for holding this hearing on the role of treatment and prevention in the national drug strategy.

For many years, I have firmly believed that addressing the problem of substance abuse in our country should be a top priority for Congress. There has been increased awareness of the dangers of substance abuse in recent years, which has resulted in substantial increases in funding and the development of resources in these areas.

The creation of the Office of National Drug Control Policy is a testament to the priority. that is being placed, on the Federal level, to combating the war on drugs.

Under the fine leadership of Dr. William Bennett, the Office of National Drug Control Policy has directed attention to the threat posed by drugs which permeates all levels of society in the United States, including the rural areas.

I am pleased that this committee will have the benefit of receiving testimony today from Dr. Bennett, who is accompanied by Dr. Kleber and Mr. Carnes, concerning prevention, education and treatment efforts relating to substance abuse.

Although my schedule will not permit me to remain for the entire hearing, as I am on three committees that are holding hearings simultaneously, I shall review with interest the testimony that is presented.

Dr. Bennett, I want to commend you again for the fine job you are doing.

Thank you, Mr. Chairman.

Dr. BENNETT. Thank you, Senator.

The CHAIRMAN. We'll be glad to recognize the Senator from Indiana for his full time, if that is agreeable.

Senator HATCH. Yes, certainly.

Senator COATS. Thank you, Mr. Chairman.

Mr. Secretary, I want to focus on some things you have said and indicated in your statement relative to the importance of programs and policy going together. We have spent a lot of time in Congress talking about programs, but we haven't spent very much time talk-

ing about policy. And we have spent time here today talking about education.

I have spent a lot of hours in Indiana talking to kids about drugs, and what I come away with is that nothing I can say is new to them; they have heard it all.

Dr. BENNETT. Right.

Senator COATS. I am another politician in there telling them not to use drugs. They have had sports stars, they have had politicians, they have had psychologists, they have had hypnotists, they have had teachers, they have had ex-junkies, they have had students, they have had films, and on and on and on and on.

I am reminded of a song that Bruce Springsteen put out several years ago that has a line in it that says, "We learn more from a three-minute record than we ever learned in school." So many of the things that kids are learning are different from what they are hearing in the schools, which points me to the whole idea of policy.

I think it was just a year ago the Department of Education released information on a study indicating that, as you know, universities and colleges that receive Federal funds have to certify that they have a drug-free program in place. That certification has been as simple as simply saying they put some literature out. And in fact, in most cases, the compliance has been a rack of literature in the student union. But 700 universities didn't even bother to reform the form; yet they still got their money—which I think indicates a pretty lax attitude on the part of the administration of those schools and universities relative to what the policy is going to be. And what message does that sends to kids? That sends a message to do your own thing; the school doesn't care. And I find that that pervades a lot of educational institutions.

So we can flood the schools with counselors; we can flood the schools with education programs, and I think there is clearly a role for education, but unless that school sets a standard, unless there is a policy there that says "No drugs in this school", those programs ultimately aren't going to be effective.

Those of us who have raised kids know that we hope they'll turn out to be model children and wonderful, and will come home at curfew time or 11:30 or 12 o'clock or whatever. What we have found is if we don't say "Be home at 12" and enforce it, they come home at 1 a.m. or 1:30, and there is always an excuse, there is always some reason why they couldn't get there—the ride didn't work out, the party went longer than they thought, they didn't look at their watch, or whatever.

We have found that when we say "Twelve o'clock or you don't go", that somehow they find a way to get home, even if the watch is wrong or the ride doesn't materialize. So I think setting the standard is very important.

I am concerned that too many schools have loaded themselves up with all kinds of fancy education programs but haven't set a policy to back that up.

Dr. BENNETT. That's correct.

Senator COATS. Now my question is this: What role should testing play in order to enforce a policy? I legitimately have some questions here as to what that role should be. There is a school in Indiana, and other schools have looked at it, that has instituted a

policy of drug testing for its athletes because they are involved in a voluntary extracurricular activity—and I passed some legislation here that is now a part of law that allows Drug-Free School Act funds to be used for that, with the governors' discretion and with the schools' discretion. What happened in this school was that the parents of kids on the baseball team came to the school board and said, "We've got some concerns that funny things are happening." One kid took at 80-mile-an-hour fast ball on the side of the face, and he never flinched, and somebody thought that maybe he was on drugs. Other kids were playing with injuries they shouldn't have been playing with, but they were masking their injuries, they thought, with drugs. So they imposed upon the school board—they begged the school board—to allow testing of the baseball team. They found one-third of the kids were on drugs. They set a standard that they are going to test on a random basis, they are going to put all the safeguards in, and if you test for drugs, you are off the team, you can't play in school.

The students supported it, the team supported it, the school supported it, the parents supported it, and the school board supported it. The American Civil Liberties Union did not; they took the case to court, and the court of appeals upheld the procedure, saying that it was not an invasion of privacy. I won't go into all the things they did to protect the students.

So I guess my question is: What role does testing play in the area of setting policy? It is one thing for principals to come forward and say there won't be drugs in the schools; it is another thing to say we are going to take reasonable steps to ensure that there won't be drugs in the schools.

What is your thinking on that?

Dr. BENNETT. Well, if I might comment first about colleges and universities. You know the new law which goes into effect in October. If these institutions do not submit and sign the form, have sanctions for drug use, and demonstrate to the Department of Education that they are taking it seriously, they will not get Federal funds, and we plan to exercise some interest in that topic.

There are still too many cases, frankly, of universities not regarding themselves as subject to the same rules and laws as everybody else—a lot of universities represented at this table and that table—but there is still a feeling among some administrators and some faculty that, you know, it is a little different here.

I was just out in Colorado and mentioned that if you're going to have a drug testing program for State employees, it is not just the cops—it is also the philosophy department at Boulder—and people got some eyebrows up. If you are going to test the State police, the philosophy department ought to be tested, too, if that is your policy.

My response on drug testing generally is: Does it make sense? I am not one who believes that in the campaign against drugs what we should do is just go out and start testing everybody who walks down the street or everybody in the school or everybody in this profession or that profession. We have made clear our plans in the Federal Government; certain secure positions, the people in our office.

But I think this was a rational decision that people at this school made. I mean, if kids are getting hit in the side of the head with 80-mile-an-hour fast balls and not feeling pain, and in other circumstances they are not feeling pain, something is going on. This was a judgment based on facts and circumstances which seemed to me to be very rational, and obviously the results showed that it was—a third of the team on drugs. There was cause.

Senator COATS. Well, I think that is the point I was trying to make with the legislation, not that we would mandate——

Dr. BENNETT. Yes, sir, and you amended it.

Senator COATS [continuing.] But that we allow people to do that if they believe that it is an effective tool for dealing with the problem. And I think you can make an argument that you are not doing it to punish; you are doing it out of compassion. You are doing it to get people into treatment. Now the school has a policy, and we'll get you into treatment right away. You are doing it because you compassionately want to keep someone from injuring or killing himself or somebody else.

And I would hope that we could allow that in factories where, operating machinery, you might not only injury or harm the operator but might damage a fellow worker down the line.

And secure positions—you and I do a lot of flying, as does every member on this panel. I like to think that the FAA controllers and the pilots are not on drugs.

Dr. BENNETT. Yes. I do fly a lot, and I fly commercially most of the time—except when I'm lucky enough to bum a ride with the President on rare occasions—but I fly commercially, and I had a run over 6 months of pilots and stewardesses coming back and asking, "Why do we all have to be tested? Do you suspect us?"

No, I don't suspect you, but you are flying an important piece of machinery with a lot of people.

Since that Northwest Airlines incident with those two guys who were drinking, no one has come back to complain.

Senator COATS. Well, I would hope that we could do some things, and I know that you share that hope, relative to policy. I am a strong supporter of the programs and of the need for rehabilitation and treatment. But I agree with you 100 percent that unless it is combined with a policy and unless we set a standard, a lot of those programs are not going to be effective, and we are going to be sending a very hypocritical message or mixed message or confused message to an awful lot of people, whether they are students or people in the workplace or wherever.

Dr. BENNETT. The thing is, if I could just comment, you are right, but the message is getting through; clearly, the message is getting clear. The chairman's charts show that the message is getting through; even with the perception of increased availability of drugs, the message is getting through, and I think it is due to a whole bunch of things that are going on. I think it is Len Bias, and I think it is education courses, and I think it is tough policy, and I think it is law enforcement, and it is probably the Ninja Turtles last Saturday, who didn't hurt.

But this is the way America goes at its problems. We have a systematic approach, but underneath the systematic approach there is

an aspect to this of let's throw everything we've got at it. And essentially that's what the strategy says.

When we were putting the strategy together, people said, "Do treatment." Other people said "Do education." Other people said "Get at the source." Other people said "More cops." We said we're going to do it all, all of it; let's do all of it—in fact, all of it times two. And that is what a lot of States are doing, too, and the message is getting through. That is why some of us are encouraged.

Senator COATS. Thank you, Mr. Chairman.

The CHAIRMAN. The Senator from Utah, Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. I won't be long.

OPENING STATEMENT OF SENATOR HATCH

Comprehensive community action stops the demand for drugs. The efforts of the Utah Federation For a Drug Free Youth, the Utah educators, law enforcement and community volunteers make demand reduction work. An improved relationship continues to grow between those concerned with supply side issues and those concerned about prevention and treatment. They both have a mutual goal: Decreasing drug use in the community.

Drug use is unacceptable; communities can make drug activity go down. We get effective demand reduction by supporting programs in the schools the community, and the home. Broad involvement is the key to successful demand reduction programs.

Many employers are concerned about drugs. We know that the largest number of drug users are in the workforce. Workplace safety and job performance concern all of us. Concern also exists over absenteeism, on-the-job injury, and loss productivity. Many of America's employers want to test employees, and many employees support drug testing programs. We need to assure that both employers and employees are protected in any drug testing program. And, there must be a chance for the public to comment on any Federal guidance on drug testing.

Dr. Bennett, one thing you have not been accused of is being slow in getting the money out to the States. The effectiveness of block grants to States has been demonstrated. We need to continue this support, which guarantees funding speed and maximum State flexibility. I do share your concern over our need to increase accountability in our drug programs. We need to be able to replicate successful programs and stop funding those that are not successful.

I know that you and your colleagues share my desire to see more done. We need to reach that 20 percent of our population that uses drugs. We need to reach those who are not in school. We need to reach those in our corrections systems. We need to renew our commitment to education and treatment. And, we must all join with you and those on the front lines to prevent drug use from starting, and to treat those who are addicted.

I would like to welcome you Dr. Bennett, and your colleagues from the Office of National Drug Abuse Policy—Dr. Herb Kleber, the deputy director for Demand Reduction; and Mr. Bruce Carnes, the director for Planning and Budget.

Dr. Bennett, in your statement you make an observation that the private treatment facilities are operating at 55 percent of capacity,

and at the same time we have waiting lines at most of our public facilities.

How acute is this waiting list problem? Is it more a problem of treatment beds being inconvenient rather than nonexistent, and can we expect the private beds in this country to resolve the problem, or to be a major source in resolving the problem?

Dr. BENNETT. That's a good question and one you are very familiar with, Senator Hatch, because I am sure you have come up with it in other contexts, and I'm sure you know the answer.

Private beds would like to be useful in some circumstances and have people who would be publicly supported in there, but also many of them like to charge their private rates. That is a problem for us.

Dr. Kleber.

Dr. KLEBER. I have met with a number of the professional hospital associations around that issue in the last couple of months, asking if we couldn't get the law amended. Right now the block grant does not permit States to contract with private hospitals. They asked if we would support changing that, and I said I would have trouble doing that because it would drain most of the money we put into treatment. The average private bed runs $500 to $700 per day or more, and I just feel that (1) very often, inpatient isn't needed, and (2) we cannot afford as a Federal Government to be paying those prices.

What I suggested to them is that they should go back to their members and ask could they see reducing the price of those vacant beds to the State agencies so that instead of $500 a day, maybe it would only cost the State agency $150 a day. And if their members were willing to do that, then I would certainly ask our office to look into exploring that with Congress to see whether it is a viable kind of alternative. But I don't think that the Federal Government should be paying those kinds of rates unless we are prepared to put an enormous amount—billions and billions more—into it.

Senator HATCH. Well, I can't help but agree with you on that. I think we ought to try and do something that might utilize those beds, but I certainly agree with the cost evaluation that you made.

We also know that the largest number of drug users are in the workplace of America.

Dr. BENNETT. Right.

Senator HATCH. I have introduced a bill that you are aware of, S.1903, "Quality Assurance in the Private Sector Drug Testing Act of 1989." I introduced this bill because of my concern and that of many employers and employees about drugs and drug testing. This bill does not encourage drug testing, but it does set forth reasonable guidelines and protections for both employers and employees. It is my contention that we need to ensure that there are protections for both employers and employees in any drug testing program, and there must be a chance for the public to comment on any Federal guidance on drug testing.

I would like to work with you and your staff on coming up with the perfect drug testing bill. I think it is something that is long overdue. One of the major concerns of America's business leaders is drug use in the work force.

In some parts of the country, employers are taking the lead in instituting drug testing programs; in others, like in Baltimore, unions are taking the lead. I am finding that a high percentage of union workers and employees across this country would like to have a testing program because they do not want to work alongside fellow employees who are using drugs.

Dr. BENNETT. That's right.

Senator HATCH. Now, how can we more effectively reach adults who are using drugs? Do we need to develop a broader workplace effort, or will community efforts actually reach this group, or in particular, the users?

Dr. BENNETT. I think both, but I think you are very much onto something here, Senator, in focusing on the workplace. And as you know, we want to work with you; there is much in that proposal of yours and Senator Boren's that we very much agree with.

I think the workplace is a very logical place to go—people's paychecks.

One of the interesting thing about the 70 percent of drug users who have jobs—those are our estimates—is that they tell us in anonymous surveys that if they thought they were going to get caught and punished, have to pay a penalty, they would stop.

So this is a way of saving ourselves some incarceration dollars later, or some major treatment dollars later, to simply adopt an up-front position which says we don't tolerate drug use; stop, or you lose your job, and where appropriate, if there is cause in a workplace situation, analogous to what Senator Coats was talking about in the baseball team, then testing.

One of the things I have been interested to find as I have been around the States is that a number of States have provisions in the law preventing employers from instituting these kinds of programs. States should not get in the way of doing this. Obviously, all the constitutional protections have to be built in and cannot be abrogated. But if employers want to go this way—and most employees want them to when you look at the surveys—they should be allowed to do it.

Senator HATCH. That's good. I think there are only, as I recall, about 16 States that do anything with regard to drug testing and protecting employers and employees. And they are all inconsistent; the regulations are inconsistent, the court cases are inconsistent, and there is no real protection, and yet some employers and employees are working it out to do it anyway. But everywhere you have drug testing, you have a much lower incidence of drug use in the workplace. And you are right, it has a very salutary effect.

I think most enlightened employers, with the labor demographics trending downward well into the 20th century, know it is going to be difficult to get high-quality employees, they are going to have an altruistic approach because if they find somebody is on drugs, they want to get them off drugs and get them rehabilitation, rather than firing them. But the threat that they might lose their job or the threat that they might have to go through rehabilitation alone would help to decrease the incidence of drug use.

Dr. KLEBER. Yes. We very clearly don't want to create a Nation of unemployables, of people who can't get jobs because they test positive. We think that people, if they do have a problem with

drugs in the workplace, should be able to get help, but at the same time there should be firm policy that we are not going to permit you to endanger your fellow workers.

When I was in California recently at the Newspaper Publishers Association, one of the printers' unions was on the platform, and he said he tells his members, "Look, if your hand gets stuck in the printing press, you don't want that guy next to you to be on drugs and hit the button that says' speed up' rather than the button that says' stop'." He sold his union on the importance of testing so that his fellow workers are not using drugs.

Dr. BENNETT. Could I comment briefly, Senator?

Senator HATCH. Sure.

Dr. BENNETT. This could prove to be a very dramatic thing. We only have preliminary information on it, but we thought it would interest you, knowing your interest and the chairman's interest and others' here on competitiveness.

We have some indications from some studies done in some major industries—this won't surprise you, but it is interesting—that there is a very strong positive correlation between drug use and consumer complaints. That is, if you track that part of the product which the consumer is complaining about—and we won't talk about which product it is—often they have found that where that complaint is, that part of the factory is where the drug use has been found to be the highest. Now, that's a hell of a comment. That is something about international standing and competition.

We are talking about in some workplaces estimates of 15 to 25 percent of people using drugs, and that is where the complaints are coming back in over the transom.

Senator HATCH. And the loss of productivity alone is costing us billions, maybe trillions of dollars in this society.

Dr. BENNETT. It is unbelievable.

Senator HATCH. Well, just one last question. I don't want to keep you. I know that these hearings are very difficult for you and take you away from what you really want to do, but they are essential, too. The American people see you and they hear you, and they know that things are being done, and so frankly, I want to commend you for all that you have done.

Dr. BENNETT. Thank you.

Senator HATCH. I have been really proud of what has gone on, but we all acknowledge we have a lot more to do.

But you spend a lot of time, Dr. Bennett, meeting with community leaders around the country. Do you feel that our local and State leaders are really willing to commit their funds to fight the drug battles, or are they just relying on the Federal Government to solve all these problems?

Dr. BENNETT. For the most part, I think they are. Again, I learned in this job what I learned in the other job at Education—the best Federal spending program is one that is deployed intelligently and responsibly at the local level. Our money is not self-spending, and it certainly is not self-spending in an intelligent way. The people on the ground have to do it right. And I think most—as I go around the country, 46 communities now—the sense you get in most communities is, "Look, we're going after this problem. We want to do something. We need some help from the Federal Gov-

ernment, but we have a plan, we have an idea." In a few places, you have people who say, "We don't have the foggiest idea what to do. The Federal Government has to save us." And in a few places, all people want to do is grouse and complain and use your visit as an opportunity to do that.

But for the most part, I think the American capacity for self-renewal is starting to work; those juices are starting to flow. It is a little bit like the boxer in the ring. I think when crack came out, it was like we were being punched and sent against the ropes and getting a little dizzy. But now I think we're getting our feet back. And as you go around and talk to most mayors, most civic leaders, most governors, they are getting a plan of action, and things are starting to work.

If you just look at the number of people who are now out of their houses or public housing projects, in the street, fighting back as opposed to hiding and letting it go on without taking steps, you can see that things have changed in the last few years. America is starting to come back.

Senator HATCH. Great. Let me just compliment our chairman for holding these hearings and compliment you folks for the work that you are doing. I know that it is a very difficult job. I also know that the Congress in its infinite wisdom did not give you all the authority and the tools that you need to really be able to accomplish everything that needs to be accomplished. I think without that authority you have done a terrific job. So I just want to commend you for everything you are doing; it is just terrific.

Dr. BENNETT. Thank you, Senator. Thank you very much.

The CHAIRMAN. Before yielding to Senator Durenberger, could I just clarify one point.

Dr. Kleber, would you want flexibility to permit you to bargain with the private sector to get prices down in the area of treatment? We could take a look at some models. Do you want that kind of authority? You don't want to spend top buck, and I can hear you. It is not a terribly great endorsement for our insurance companies that they are charging that kind of money and consumers are paying for it. But that aside, would you want some authority so we could try and permit you in half a dozen or a dozen different areas in the country to see if you could leverage those and get some kind of cut-in costs?

Dr. KLEBER. I would certainly like to look at that——

The CHAIRMAN. All right. Do you want to work with us on that? I think that would be helpful. Before yielding to a member of the Finance Committee, who probably understands this a lot better than we do, on the leverages, I understand with the exception of the V.A. in terms of leveraging, that with all the money that we purchase in health care, we don't really leverage the whole system nearly the way we could in terms of reducing the cost of health care. That is a different issue for a different time, of course.

Dr. BENNETT. I think that is certainly true.

The CHAIRMAN. If you want to take a look at that, I would certainly be open. I am sure there are some obvious problems that just do not come to mind, but I think we're going to keep after you in terms of this treatment, where if we could give you some flexibility in some of these areas, it may be worthwhile.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

As the ranking member leaves the room, I want to start with something that he said as almost an afterthought, and that is that you would rather be somewhere else right now, and I'm not going to ask you that question as to where you'd like to be because I'd like to hear you say that you'd like to be right here.

I have been looking at the chairman's charts over there, and the reason that I think there is some value in being here—and I think this is your first appearance before this committee—is that, at least for this member of the committee, and I suspect for some of the others about my age, it sort of traces the delayed adolescence of some of our own kids.

My oldest, who is just 27, probably started using in about 1975 or 1976. I don't know how they picked those particular dates on the charts, but I think it does reflect the experience that a lot of people in this body have had, and I just wanted to link this with what the ranking member said, that it is probably to our benefit that you do get to spend a little time with some of us either in this setting or some other setting, because I like your statement a lot. I think that the statement, while it is of necessity brief, correlates, at least in my personal experience, with the direction and the emphasis and the definition of the problem, before you come up with all the fancy solutions, that I'd like to see my national Government and my national policy go.

I love the quote from Bill Raspberry about education being the solution only insofar as ignorance is the problem.

Second, I like the points you make about the strategy for the community partnership, and the discussion we had this morning on treatment.I am happy to say that my State is one of those States where you can walk in practically any door.

Dr. BENNETT. Yes, it is a model State.

Senator DURENBERGER. But the point that you made, or one of you made, about are you walking in the right door is Minnesota's problem. And if we are talking about putting resources in the right place, Minnesota would say to you that we don't need more treatment centers; we need some diagnostic help, we need some evaluation help; we need to get the folks in the right place at the right time. So I am pleased when I see the stress you put on block grants.

I heard you mention here the need for insurance reform. I am going to do something in a few weeks on major health insurance reform—I mean just restructuring this whole system—because the financing system has too long been dictating the diagnosis and the treatment and everything else. And I like that a lot.

I also like the idea of a definition of priority population. We could probably disagree on some of this, but I don't know who can disagree on targeting pregnant addicts; who can disagree on targeting adolescents; who can disagree on prison inmates and so forth. Why don't we go where we have the greatest payoff in the largest sense for the country? I like that a great deal.

You express disappointment with our failure to require Statewide treatment plans, and there may have been different reasons why we did that, but I think that says a lot about a national policy

that depends on the States' commitment to plan this approach according to the willingness of the States to make certain investments in certain areas. Some States want to be the labs. My State wants to be a laboratory for the rest of the country, and we have the capacity to do it, we have the willingness to do it, we've got the experience; everybody looks up to Minnesota for these sorts of things anyway, the so-called "Minnesota model." But some other State should not be criticized in some way nor forced to reach the Minnesota level. I think that there is enough to learn by fortifying some of the things we do with the flexibility to put our resources in the right place.

But anyway, doing something by way of planning and not making it a requirement that every State's plan look alike, it seems to me, your expressed disappointment is appropriate.

Then the last thing that I noticed on your statement that I wanted to stress and ask you a question about is where you state that, "On of the most important Federal roles in improving drug treatment is the support of promising new models and methods, and basic and applied research." When I think about national purposes and how best to use the national government, I try to think about the thing you don't have to re-invent 50 times.

In the area of basic and applied research, you mention a number of things, but things that I don't see there are some of the things that relate to addictive behaviors, that relate to genetic dependencies, that relate to some of the things that cut across the lines of mental health and chemical dependency. Another thing I don't see in your comments is work on outcomes. We are just starting our work in other areas on health outcomes and so forth, but maybe you could begin by addressing the status of Federal research in those particular areas which should have value to all of our States.

Dr. BENNETT. Sure. I think we are working in those areas, and I'll ask Dr. Kleber to comment.

Could I comment briefly, though, on a couple of your points?

Senator DURENBERGER. Sure.

Dr. BENNETT. On where I'd rather be—on balance, here, I guess; I think Minneapolis-St. Paul might be preferable, although I just came back from a visit there. I don't want to appear to be a delicate flower here, because I'm not, about coming to hearings. It's not that I don't like it. This is my 19th appearance before Congress since September. And I love pizza, I love lots of things—but 19? You know, it's enough at some point. But this is obviously a very important committee, and we are glad to have this opportunity, and I think this has been a very worthwhile conversation.

Senator DURENBERGER. I'd just got to say in my first year here in 1979, Jim Schlesinger was the Secretary of Energy, and I think he spent about two-thirds of his time in front of committees. Now, that may or may not have been excessive, but it reflects the fact that energy was a priority in 1979.

Dr. BENNETT. You bet; tremendous interest, and that's great.

I would just comment that Minnesota is a model in treatment, but it isn't necessarily a model for everybody else. I think it will be differently configured in different places.

It was interesting to go to Texas and Minnesota, one right after the other, because I think each State could learn from the other. I

think Texas could learn much about treatment from Minnesota, but Minnesota could probably learn a little bit on law enforcement from Texas. There is still a little softness in the air up there about marijuana.

Senator DURENBERGER. Yes. It is the only State that didn't support Ronald Reagan or George Bush for President. That tells you something.

Dr. BENNETT. Yes. But it was interesting to talk to people; they are very tough and very sensible—except when it came to marijuana. They said, "What does that have to do with it?" Well, it's got a lot to do with it; it is how we got there. That's unfair. I think most people agreed with our sentiments, but there was some need in the State legislature to take some more serious action because there are reports that some of the marijuana growers were on their way to Minnesota, perceiving a softness in the law. This is one of the interesting things we have learned. But you are quite right—there is a lot more good going on in that State legislature and their plans than not.

The idea of accountability is not to have uniformity, but to have accountability, and each State has to respond to its population in different ways. You've got a relatively unique set of circumstances in Minnesota given the population. And then you have a situation in Minneapolis-St. Paul which is different than a lot of the rest of the State. I am telling you things you already know.

In terms of the research, I think the areas that you mentioned, we are actually going to cover—Dr. Kleber?

Dr. KLEBER. Let me just say a few words on it so I don't take up the committee's time. As far as the genetics, alcoholism is much more advanced than drug abuse in looking at the genetics, partially because given the ubiquitousness of alcohol, in general, if you are going to become an alcoholic you can become one, so that it is easier to study the genetics of that than to study the genetics of illegal drug use, where drugs often aren't readily available, and so you don't know whether someone would have become a drug addict if that drug was being sold on his street corner.

So the evidence is much clearer that there is a genetic base to some forms of alcoholism. At this point there is no similar evidence of a genetic basis to drug abuse other than if you look at the families of drug abusers, there is a higher incidence of alcoholism among the fathers, and prescription drug abuse among the mothers. But it isn't at the same State as alcoholism research, and NIDA is trying to improve on that.

As far as addictive behavior, NIDA is looking at that both with grants to various universities as well as the Addiction Research Center. I'll just mention two or three things.

The Addiction Research Center is looking into serotonin levels, does this correlate with aggression——

The CHAIRMAN. What levels? Excuse me?

Dr. KLEBER. Serotonin, which is a hormone in the brain; does this correlate with aggression, and are people with low levels more inclined to use drugs when they get older.

Dr. Callum at Johns Hopkins is looking at risk factors such as shy-aggressive behavior in 3rd graders and finding that the shy-aggressive youngster, the so-called "bully", who is also a loner, is

more likely to use drugs when he is a teenager, and now is looking into can we modify that, can we intervene in those 3rd graders to change that.

There is a psychiatrist in Washington whose name escapes me whom I met with a couple of weeks ago who is looking at resiliency and what do we know about resilient families, what can we say about youngsters in these high-risk areas who still do not use drugs, and what is it that is going on.

As far as outcome evaluation, Office of Treatment Improvement is doing that, and NIDA is doing that. So I think there is a good amount of research in those areas, both in our universities across the country and at ARC—not as much as I would like, partially because there was a drought for many years, and we don't have as many in the way of trained researchers as I would like to see. My hope is that if we can keep the research funding steady and gradually increasing, we will reassure the scientific community that this is an area you can do research in, and funding will be there, and we'll be able to attract the best and brightest into the field.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. Just one other question that deals with the issue of availability of treatment, and that is the issue of professionals. I don't know whether that question has been asked and answered here yet. At some point it is not just a matter of beds, it is a matter of people, and that is both on the evaluation side, the treatment side, the education side, the aftercare side, where in our State we have a serious lack.

What is the status nationwide currently as we look across the professionals, both in terms of the availability of education and compensation to keep them from going into other professions?

Dr. KLEBER. It is a troubled area. As we said in the strategy, the two things that are most impacting our difficulty to expand treatment are treatment sites and the availability of qualified and trained staff. It is hard to get good staff. A lot of people don't want to go into the field. The compensation levels have been historically low.

We are trying to improve that, both as we improve funding for treatment, the compensation level should rise; we are trying to improve training in our medical schools, in our nursing schools, in our psychology, in our social work schools. There are various kinds of programs that ADAMHA is setting up in those professional schools to try and increase our ranks of skilled providers.

When I talk with the head of the AMA and they say, "We doctors want to be involved in the fight on drug abuse," I say, "Well, you've got to encourage more doctors to be willing to do it." We don't have enough doctors who are willing to go out and work with addicts. There need to be more.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Let me just say in our prevention package, which we got stalled on the issue of testing—people have strong views about it—it wasn't in our jurisdiction, quite frankly. It got tagged on as an amendment; it got tagged on eight different bills. I know people feel strongly about it, but it has been held hostage.

We'd like to work with the administration and see if we can't find some way of dealing with that issue. We know where you are

coming from on this issue. On the kinds of things that Dr. Kleber has pointed out in terms of training of personnel, we had some very good programs in that legislation which we had worked out in a bipartisan way, and it is really a shame that we can't move it because we get caught up on this; it is something which is outside our jurisdiction. That is the way the system is, and there is not a satisfactory answer to our failure to deal with it, but we are trying to see if we can't find some way of moving forward with it, and if we can work with you, maybe we can find some way of going through it.

Finally, and then we'll adjourn, I'll give to your staff two pages of still stirring testimony from Jeffrey Miller, who is the principal at W.R. Thomas Middle School in Miami, and also an 11th-grader who testified. This school is situated in a neighborhood that was once labelled by the *Miami Herald* as "Cocaine Alley". It's got everything—and I hope they are still there today, but they were there a year ago.

Mr. Miller stated in his testimony: "Through our Project Trust program, we have addressed the contemporary issues affecting the lives of young people. Every incoming student is exposed to this curriculum, which emphasizes the development of self-esteem and makes no allowances for substance abuse."

It seems that they have a pretty balanced program. He talks about, "In previous years, the community's image of W.R. Thomas was not at all favorable. Incidents of possession and sale of drugs on and around school grounds encouraged parents to send their children to other schools."

He continued: "Based upon Florida statutes and Dade County district procedures, our school policy emphasizes a' Zero Tolerance' message to the entire student body. We have severe consequences for the sale and repeated use of drugs, and this is paramount in establishing a long-range drug-free environment."

It would seem to me that that represents about as tough as you can get in terms of law enforcement and also the balance in terms of education. They indicated they had not dismissed one individual, after a 4-year period.

It is that kind of balances that we are—at least for me—all trying to look toward.

Let me just conclude——

Dr. BENNETT. You are exactly right. If I could very briefly comment—and it is appropriate to come to a conclusion here—that I am glad you picked that example, because if you had asked me to pick one, in fact, I would have picked that one because I visited that school. So I think we agree 100 percent on it.

The CHAIRMAN. Good.

We didn't spend the time, because we can wrestle around for hours on these budget figures, but in terms of the ADAMHA, the block grants, the drug abuse treatment and the education, it is a very modest increase. It goes from $539 million to $593 million, so it is about $75 million when you take out the increased costs. And you've got a lot of other programs, and I won't go into it because we are winding up the hearing, but we should not be under any illusion that even with a significant increase in the resources that the school districts are going to get, that this is a great infusion of

additional funds in terms of those programs. We have an increase in the treatment programs in ADAMHA, which have gone up, which deal with a lot of the things that we have talked about here.

Dr. BENNETT. Right.

The CHAIRMAN. Last, let me just give you about a minute to talk about gateway drugs. In our society, we are trying to deal with substance abuse, and on the other hand we are seeing the billions of dollars that are expended in terms of tobacco targeted advertising and also the advertising that is done, obviously, in terms of liquor. So those are on the one side, and we are trying to deal with these issues on the other, and I think it is particularly vulnerable in the area of the gateway drugs.

I would be interested if you could make a brief comment about the importance that you place in terms of coming to grips with that particular problem.

Dr. BENNETT. Sure. By law and by predilection in our prevention and education programs, I think there is a very important place for talking to young people about cigarettes, about booze, and about the harm and damage they do; and there is some evidence and research to suggest—that Rand and Hilton study that you were talking about—that you can have some effect on student use of these.

I think the Rand-Hilton suggests that cigarette consumption could be more likely affected than alcohol consumption. But nevertheless these things run together.

For a lot of young people, too, when they look at alcohol, for example, they know it is illegal for them to use, and so it has the same status in their mind as some of these illegal drugs.

There are may places, therefore, for overlap and treatment of the two or the three in similar ways. But there are distinctions as well. We recognize that alcohol is legal; it is very traditional in our society. We equate abuse of alcohol with the use of illegal drugs for adults. So there are ways in which they overlap, and there are ways in which they are different.

I think we need to talk more about this because I think there are problems in trying to collapse all harmful substances into one package. I know the Congress thought that through fairly carefully before it created my position and had some limitations put on it, or focus put on it, in terms of controlled substances.

It makes a great deal of difference whether you are talking about the person who is in this job, trying to present a strategy to deal primarily with controlled substances or with every harmful substance. It makes an entirely different focus.

It is fair enough to say that the mood of the country has shifted so that we are seeing at the present time—I think everyone knows—a reduction in cigarette use, smoking, around the country, but also a per capita reduction in alcohol consumption, and a fairly dramatic, or at least some significant reduction in adult consumption of alcohol.

Young people continue to binge drink, and that is a problem and one that needs to be addressed.

I think that is pretty much how we see it.

When you talk about the treatment side, which I know is the focus of our hearing, what most people in treatment will tell you is that most of their clients or patients are poly drug users—they

drink and they use illegal drugs—and you have to get at all of them.

So the universe in reality is not as neat as we might want to divide it, but I think we need different strategies and different tactics at different points of time for addressing these problems.

Herb?

The CHAIRMAN. Let me ask just an informational question. I don't know what you can tell us about the addictive personality. Do you find that the people who use drugs drink a lot, or is it the people who drink a lot also use drugs? Which is it?

Dr. KLEBER. The pure alcoholic or the pure addict is a rarity these days. Although you are more likely to find that a person who abuses drugs also abuses alcohol than vice versa, I think you still find that the majority of people who abuse alcohol also abuse either prescription drugs or at least one or more of the illegal drugs. There is a lot of overlap there.

The CHAIRMAN. OK. We want to thank you very much. We didn't talk much today about some of our old questions, Mr. Bennett; we'll leave those for discussion at another time.

Dr. BENNETT. Let's go for 20.

The CHAIRMAN. We appreciate it. This has been very helpful, and I must say it has been encouraging, at least from my point of view.

We look forward to working with you on these matters and others. Thank you very much.

Dr. BENNETT. Thank you, Senator.

Dr. KLEBER. Thank you for your courtesy.

[Whereupon, at 11:50 a.m., the committee was adjourned.]

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